



## **Report to the Legislature**

### **Exceptional Care**

RCW 74.46.508 (2002)

December 12, 2002

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# **Exceptional Care Report to the Legislature**

## **Executive Summary**

RCW 74.46.508, passed by the Legislature in 1999, authorized the Department of Social and Health Services (DSHS) to increase the direct care component rate allocation calculated under RCW 74.46.506(5) for residents who have unmet exceptional care needs as determined by DSHS in rule. Additionally, RCW 74.46.508 authorized DSHS to create a pilot exceptional therapy care program for up to 12 facilities, by increasing the rate for facility residents under the age of 65 who are not eligible for Medicare, but could achieve “significant progress in their functional status if provided with intensive therapy care services.”

RCW 74.46.508(1)(b) and (2)(b) requires DSHS to report to the legislative fiscal and health care committees. The following report details were requested:

- RCW 74.46.508(1)(b) requires a report addressing the exceptional care programs for ventilator/tracheostomy clients (Medical Assistance Administration) and for children (Aging and Disability Services Administration-Management Services Division). These sections of the report address:
  - (i) The number of individuals on whose behalf exceptional care payments have been made under this section, their diagnosis, and the amount of the payments; and
  - (ii) An assessment as to whether the availability of exceptional care payments resulted in more expedient placement of residents into nursing homes and fewer and/or shorter hospitalizations.
- RCW 74.46.508(2)(b) requires a report addressing the exceptional therapy care pilot program (Aging and Disability Services Administration- Home and Community Services Division). This section of the report addresses:
  - (i) The number of individuals on whose behalf therapy payments were made under this section, and the amount of the payments; and
  - (ii) An assessment as to whether the availability of exceptional care payments for therapy care resulted in substantial progress in residents’ functional status, more expedient placement of residents into less expensive settings, or other long-term cost savings.

### **Exceptional Care- Ventilator/Tracheostomy Program**

- (i) *Average annual number of clients served (rounded):* 145 adults  
*Average annual cost per client (rounded):* \$171,000  
*Typical diagnosis of clients served:* Respiratory  
Failure/Pulmonary Complication; Neuromuscular  
Dysfunction; Spinal Cord Injury; Other, e.g. cancer of neck  
and asthma

- (ii) Exceptional Care payments have allowed these clients to obtain placements in skilled nursing facilities instead of hospitals. This has resulted in stability for the clients and a cost savings to the state.

#### **Exceptional Care- Children's program**

- (i) *Average annual number of clients served (rounded):* 7 children  
*Average annual cost per client (rounded):* \$88,000  
*Typical diagnosis of clients served:* respiratory problems, seizure disorders and cerebral palsy; average developmental capacity age- 6 months.
- (ii) Exceptional Care payments have allowed these children with medically-complex diagnoses to obtain a stable placement in the only pediatric nursing facility in the Pacific Northwest.

#### **Exceptional Therapy Care Program**

- (i) *Number of clients served:* 67 adults  
*Average additional cost per client (for average length of stay):* \$4,600/client  
*Total Exceptional Therapy Care Program Cost (est):* \$306,000
- (ii) The average length of stay for nursing facility residents served under the exceptional therapy care program was, on average, longer than that of residents with the same clinical characteristics who were served in nursing facilities without the exceptional therapy care enhanced rate. The data from this pilot program does not provide evidence that the availability of exceptional therapy care payments improved resident discharge placement, or length of stay. The data does not provide evidence that the pilot program is cost effective. DSHS does not recommend that this program be continued after the legislation expires on June 30, 2003.

# **Section 1**

## **EXCEPTIONAL CARE: VENTILATOR/TRACHEOSTOMY PROGRAM**

### **Medical Assistance Administration**

#### **I. Introduction**

This section addresses the exceptional care program authorized for ventilator/ tracheostomy clients. DSHS is required to address the following aspects of the program in this section of the report to the legislature, as required by RCW 74.46.508(1)(b):

- i. The number of individuals on whose behalf exceptional care payments have been made under this section, their diagnosis, and the amount of the payments; and
- ii. An assessment as to whether the availability of exceptional care payments resulted in more expedient placement of residents into nursing homes and fewer and/or shorter hospitalizations.

#### **II. Background**

DSHS expenditures represent about one-third of the total state budget. By far, the strongest budget pressures in DSHS are now in programs with medical-related expenditures. This includes the agency's Medical Assistance Administration (MAA), which provides coverage for 17 percent of state residents.

Presently there are approximately 941,670 residents eligible for Medical Assistance Services, covered either under the Health Option (HO) or Fee for Services (FFS) Programs. The FFS eligible are approximately 327,946. MAA's total expenditures reflect 42% of the DSHS budget. During cost year 2001 MAA expended approximately \$439 million for FFS inpatient hospital payments (excluding psychiatric care).

Adult Medicaid clients, with highly complex medical conditions and severe respiratory problems requiring long-term mechanical ventilation or tracheotomies had very limited options for being transferred out of the Inpatient Intensive Care Unit (ICU); weaned from mechanical support, or even considered for discharge, due to lack of an appropriate alternative placement. A very small number of clients who were medically stable could be discharged home with private duty skilled nursing. However, the majority of clients remained hospitalized, which is an expensive placement option for clients, as well as negatively impacting their quality of life. If a client with a ventilator/tracheostomy was transferred to a nursing facility, the client was often re-hospitalized due to frequent respiratory infections, because the nursing facility was not equipped or expected to handle acute respiratory conditions.

To address the issues of long-term ICU placement, increasing expenditures, poor outcomes and quality of life for these clients, a group consisting of DSHS, the community medical long term care clinicians, nursing facilities, and a respiratory company, implemented an intensive respiratory program in a nursing facility setting. This program addressed the medical needs of

these clients, including actively weaning clients from mechanical support (when possible), improved the clients' quality of life, and provided a less costly alternative to hospitalization.

### **III. Status**

In September 1999, DSHS entered into a special agreement with Advance Lifeline Services, Inc. (ALS). ALS is a national corporation that has numerous contracts with other states to provide intensive respiratory care services to medically complex clients with severe respiratory disorders requiring mechanical ventilation or tracheostomy support. ALS had a proven track record of successfully weaning clients off a ventilator or tracheostomy while decreasing respiratory infections in a nursing facility setting.

DSHS and ALS partnered with five nursing facilities to provide exceptional nursing and respiratory services, supplies and equipment to Medicaid clients. These are:

- Pacific Specialty and Rehabilitative Care, Vancouver, WA
- Rainier Vista Care Center, Puyallup, WA
- Bel Air Health Care Center, Tacoma, WA
- Seattle Medical and Rehabilitation Center, Seattle, WA
- Regency at Northpointe, Spokane, WA

These five facilities provide 117 statewide beds for ALS ventilator/tracheostomy clients who are medically complex and deemed "unweanable" from their ventilator or tracheostomy. Unweanable means a client who has failed numerous attempts to take them off their mechanical ventilation or plug their tracheostomy so that they breathe on their own. If these clients were not cared for by ALS in a nursing facility setting, then their care would have to be maintained in an acute hospital setting.

During FY 2001, ALS provided care to 142 ventilator/tracheostomy clients in a skilled nursing facility. The total number of clients served under this program is more than the total number of statewide beds due to some clients not staying for the entire year. The general diagnoses of these clients were:

- Respiratory Failure/Pulmonary Complication
- Neuromuscular Dysfunction
- Spinal Cord Injury
- Other, e.g. cancer of neck and asthma

During FY 2002 ALS provided care to 148 ventilator/tracheostomy clients in a skilled nursing facility. The general diagnosis of these clients were:

- Respiratory Failure/Pulmonary Complication
- Neuromuscular Dysfunction
- Spinal Cord Injury
- Other

Due to the statewide availability of 117 alternative nursing facility beds for ALS clients there has been no undue waiting time to place the ventilator/tracheostomy client in one of these beds.

ALS has structured their program to support aggressive pulmonary hygiene on all clients resulting in a significant reduction of recurrent respiratory infections that would require re-hospitalization for respiratory infections, except in extreme situations. Constant 24 hours, seven days a week respiratory monitoring resulted in early identification and treatment of pulmonary disease/dysfunction exacerbations instead of unknowingly allowing the client's conditions to deteriorate to a point requiring re-hospitalization. The ALS clients also do not need to be re-hospitalized to have their tracheostomy tubes replaced or to have blood gases drawn. These procedures are performed in the nursing facility instead of the hospital.

The following table demonstrates that clients cared for by the ventilator/tracheostomy program cost less than if they were cared for in a hospital setting. The ventilator/tracheostomy average yearly cost/per client includes room/board, nursing and respiratory services, respiratory equipment and supplies. The hospital average yearly outlier cost/per client includes everything in ALS' yearly cost except we can not identify respiratory equipment and supplies so they are not included in this average cost.

Table 1

<b>Hospital average yearly outlier cost/per client</b>	<b>ALS average yearly cost/per client</b>
<b>\$193,000</b>	<b>\$171,000</b>

DSHS saves approximately \$22,000 per client per year when cared for by the ventilator/tracheostomy program rather than in the hospital. The following table shows how much money DSHS saved in FY 01 and 02.

Table 2

<b>FY 01 (142 ALS Clients)</b>	<b>FY 02 (148 ALS Clients)</b>
<b>\$3.1 million savings</b>	<b>\$3.3 million savings</b>

#### **IV. Summary**

DSHS has experienced fiscal savings due to the ability to increase the direct care component rate allocation for a specific nursing facility population. This is a program that benefits both DSHS as well as the clients. The program has given the ventilator/tracheostomy clients enhanced quality of care due to the ventilator/tracheostomy program providing stability and continuity for their medical conditions. Also, the clients' quality of life is enhanced due to a more home-like environment the nursing facility provides rather than a sterile clinical environment of an intensive care unit.

## V. Recommendations

DSHS recommends the following:

1. Continue the special agreement to provide services to clients who have unmet exceptional care needs
2. Continue contracting with ALS
3. As necessary, expand the contract to include 1-2 additional nursing facilities



**Section 2**  
**EXCEPTIONAL CARE- CHILDREN'S PROGRAM**  
**Aging and Disability Services Administration**  
**Management Services Division**

Currently, DSHS pays for the care provided to seven children from Washington State residing at Providence Child Center in Portland, Oregon. Under RCW 74.46.508, DSHS was given authority to establish criteria for these payments. WAC 388-96-781 provides the following:

**WAC 388-96-781 Exceptional direct care component rate allocation -- Covered Medicaid residents.** A nursing facility (NF) may receive an increase in its direct care component rate allocation for providing exceptional care to a Medicaid resident who:

- (1) Receives specialized services to meet chronic complex medical conditions and neurodevelopment needs of medically fragile children; and
- (2) Resides in a NF where all residents are under age twenty-one with at least fifty percent of the residents entering the facility before the age of fourteen.

The children that are placed at this facility are placed there because there is no other comparable facility in Washington. Providence Child Center is the only pediatric nursing facility in the Pacific Northwest. The residents at this facility are children who are developmentally disabled and have a multitude of clinical problems. Some of the diagnoses include respiratory problems, seizure disorders and cerebral palsy. These children cannot walk or talk, and the average developmental capacity of residents at this facility are that of a six month old.

The current rate that Providence Child Center receives to care for these seven individuals is \$243.53 per day per child. The average number of children from Washington who lived at the Providence Child Center that was paid for the care provided is shown below.

Table 3

**PROVIDENCE CHILDREN'S CENTER**

<b>YEAR</b>	<b>NUMBER OF RESIDENT DAYS</b>	<b>MEDICAID AMOUNT PAID</b>	<b>AVERAGE PER RESIDENT DAY AMOUNT</b>	<b>AVERAGE # OF RESIDENTS PER DAY</b>
<b>2000</b>	<b>2,847</b>	<b>\$610,272.50</b>	<b>\$214.36</b>	<b>7.78</b>
<b>2001</b>	<b>2,516</b>	<b>\$576,088.88</b>	<b>\$228.97</b>	<b>6.89</b>
<b>2002</b>	<b>1,663</b>	<b>\$404,982.26</b>	<b>\$243.53</b>	<b>6.84</b>

- Information on the above chart for cost year 2002 is through the month of August 2002.

Because this is a unique program, the placement of these children in this nursing facility was never intended to result in a more expedient movement of these individuals into a less costly environment. In most circumstances, an alternate care setting for these children would be a hospital, which would be more costly than this pediatric nursing facility. The ages of the

Washington resident children range from 5 years old to 20 years old. These children will probably reside in their present location at Providence Child Center until they reach the age of 21.

If care for these children were provided in a hospital rather than a pediatric nursing facility, the average yearly outlier cost per resident would be approximately \$193,000 per year. The table below demonstrates the savings per resident by placing these children at the Providence Child Center.

Table 4

<b>Hospital average yearly outlier cost per resident</b>	<b>Pediatric nursing facility average cost per resident</b>	<b>Savings to state per resident</b>
<b>\$193,000</b>	<b>\$88,000</b>	<b>\$105,000</b>

With an approximate savings of \$105,000 per resident per year, the savings to the state by providing care for these children at the Providence Child Center is approximately \$735,000 annually.

**Section 3**  
**EXCEPTIONAL THERAPY CARE PROGRAM**  
**Aging and Disability Services Administration**  
**Home and Community Services Division**

**I. Background**

This section addresses the Exceptional Therapy Care (ETC) portion of RCW 74.46.508, and covers the time period from January 2000 through July 2002. The ETC program applies to residents in 12 pilot nursing facilities (NFs) throughout the state. ETC includes intensive skilled therapies for nursing facility residents, including physical therapy, occupational therapy and speech therapy. Eligible residents are “under the age of 65, not eligible for Medicare, and are able to achieve significant progress in their functional status if provided with intensive therapy care services.”

RCW 74.45.508(1)(b) directed DSHS to write a report that includes:

- the number of individuals on whose behalf therapy payments were made, and the amount of the payments
- an assessment as to whether the availability of exceptional care payments for therapy care resulted in substantial progress in residents’ functional status, more expedient placement of residents into less expensive settings, or other long-term cost savings.

**II. The Exceptional Therapy Care Program**

**A. Selection of Facilities**

RCW 74.45.508 authorized up to 12 pilot nursing facilities to receive an increase in the direct care component of their rate for ETC programs. DSHS developed selection criteria that were shared with all of the NFs in the state. Interested NFs submitted an application to become a pilot facility. The applications were evaluated, using the predetermined criteria, by staff from DSHS’s Residential Care Services, Home and Community Services, and Management Services divisions. Twelve NFs were selected to participate in the ETC program; four in Eastern Washington and eight in Western Washington.

In 2001, DSHS conducted a review of the pilot facilities and discontinued the program for two facilities, related to quality of care concerns. A third facility closed. DSHS again sent out a letter of interest to all the NFs in the state. The process for selection described above was again followed and three additional NFs were added. There were four pilot NFs in Eastern Washington, and eight in Western Washington. In May 2002, one NF on the west side of the state closed, so there are currently 11 NFs participating in the pilot program.

## **B. Resident Criteria**

The department specified in rule that the ETC residents must have at least one of the following diagnoses:

- Traumatic Brain Injury (TBI)
- Major Multiple Fractures
- Paraplegia
- Quadriplegia
- Cerebrovascular Accident (CVA)/Stroke

Intensive therapy was defined as two hours a day, for five days a week. The time can be any combination of skilled therapies.

## **C. Process For Authorizing ETC**

The process for ETC authorization was structured so that it would be easy to administer and benefit the participating resident. It was designed with the assistance of DSHS field staff responsible for completing the monitoring reviews. The process is as follows:

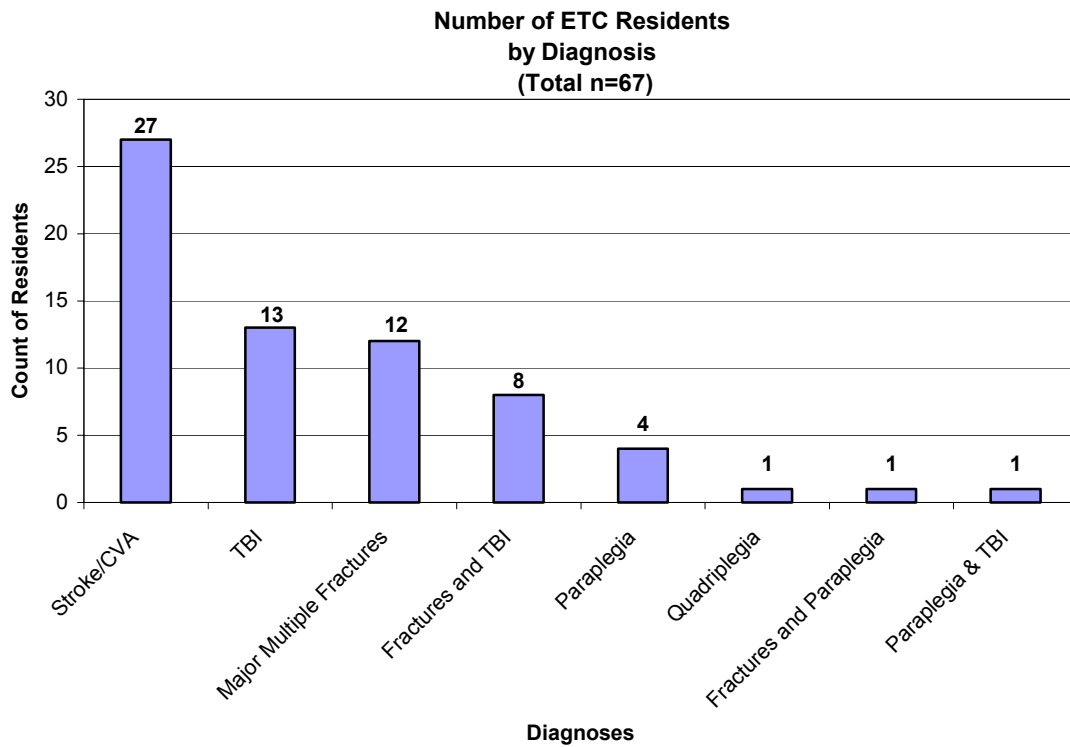
- The NF submits a referral form to DSHS headquarters.
- After a paper review to ensure that the qualifying criteria are met, an initial five-day authorization is given so as to not delay the therapy start date.
- The Community Nurse Consultant (CNC) conducts an on-site review to authorize continued participation in the program. He or she attends the NFs interdisciplinary team meeting in order to monitor the resident's progress toward the rehabilitation plan of care, and validate that the intensive therapy is being provided. The visits include an interview with the resident. The CNC usually authorizes the ETC for one week, but does have the option of reauthorizing for up to a month at a time.
- The CNC communicates this information back to headquarters.
- The ETC data collected by the CNCs is entered into a headquarters database. Information includes name and age of the resident, name of the NF, resident's date of birth, diagnosis, date of admission, where they were admitted from, how long the resident was in the ETC program, whether or not the resident was discharged at the end of the ETC program, date of discharge from the NF, and the discharge location.
- Data on measuring functional status was also obtained from the NF staff. The Functional Independence Measure (FIM) tool was originally considered, but further research determined it to be too expensive and impractical. There were several issues: the FIM tool is copyrighted, it would be expensive for the state to utilize, and NF staff would need to pass a certification exam prior to using the tool. Currently most NFs use a modified version of the FIM, but these vary from one NF to another, and therefore could not be used.
- With provider input, DSHS decided to use a version of the Minimum Data Set (MDS) known as the MDS-PAC tool. PAC is the acronym for Post Acute Care. The Activities of Daily Living (ADLs) in this tool have been cross-walked with the FIM, it is free, and the coding concepts are familiar to NF staff. Data was collected at regular intervals (days 5, 14, 30, 60, 90), and upon discharge from the ETC program.

### **III. Results**

#### **A. Clinical**

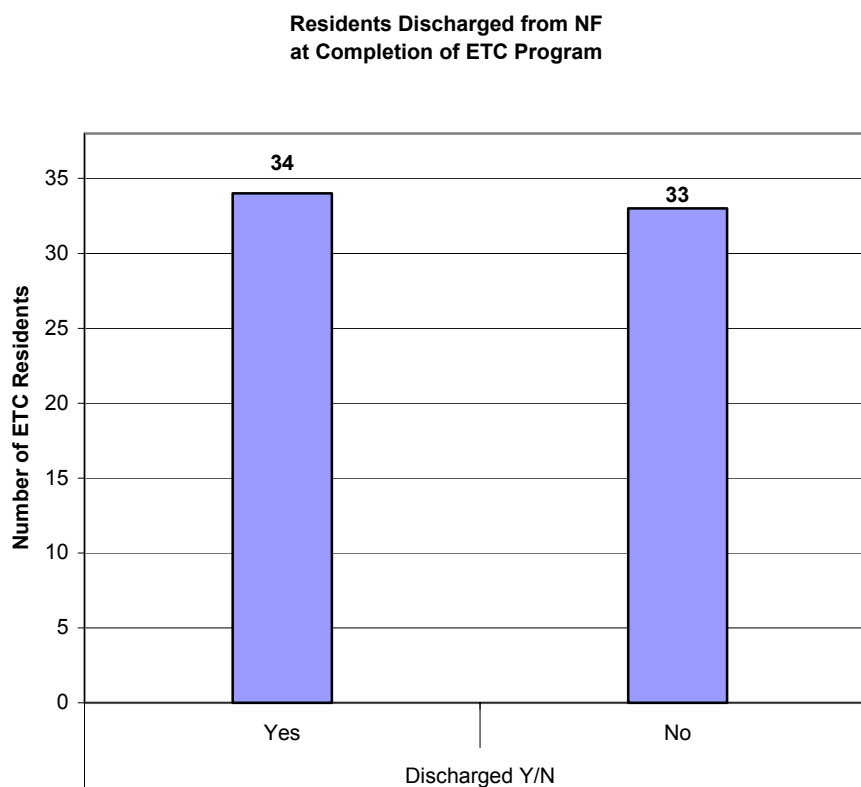
DSHS analyzed data for the time period of January 2000 through July of 2002. There were a total of 67 residents in the ETC database. Since a few of these clients were still receiving therapy at the end of July, some information (discharge, final MDS score, etc) is not available. Chart I depicts the number of residents by diagnosis.

Chart 1



Some of the residents were discharged from the NF upon completion of the ETC program; others were discharged at a later date. Chart 2 illustrates that only half of the residents were discharged from the NF at the completion of their ETC therapy.

Chart 2

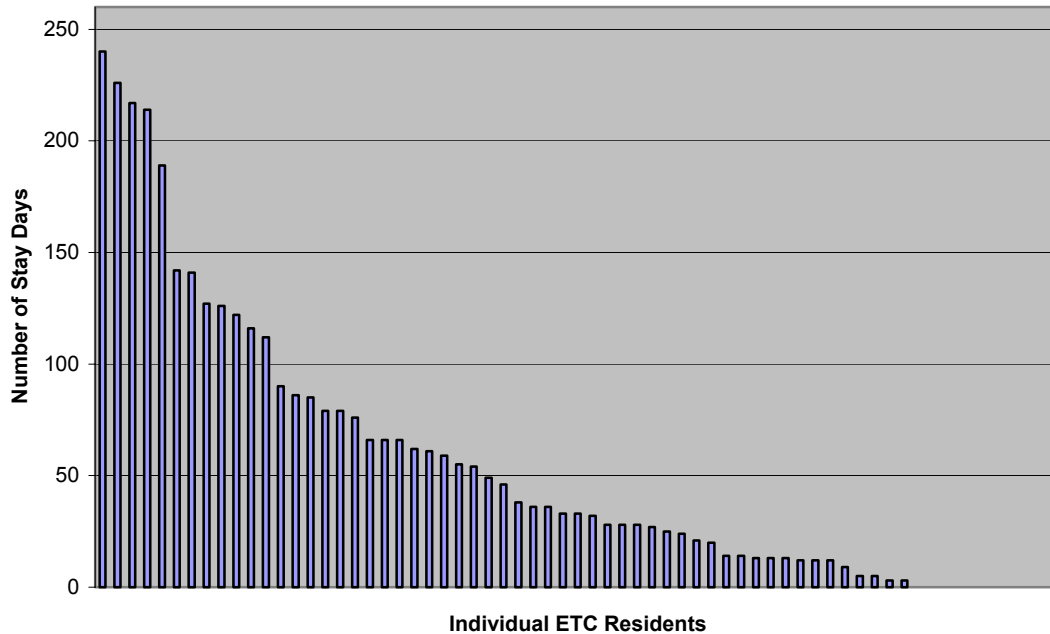


Length of stay (LOS) data was available for 55 of the 67 ETC residents. The LOS was calculated by counting the number of days from admission to discharge from the NF. The LOS ranged from a minimum of 3 days to a maximum of 554 days, with an average length of stay of 75.3 days.

The one resident who had a stay of 554 days was considered an outlier, as there were no other residents who approached that length of stay. When the data was run (excluding the outlier resident) the range was 3 days to 240 days with an average of 65 days. Chart 3 depicts the LOS data:

Chart 3

**NF Length of Stay for  
ETC Residents  
(Avg LOS = 65 days)**



Since this average seemed high, NFs that had at least three ETC residents were examined to determine whether there was a difference among them regarding the LOS data. Table 5 shows the range, and that three out of the seven NFs exceeded the average LOS. There was no single NF that appeared to raise the average LOS for all of the pilot NFs.

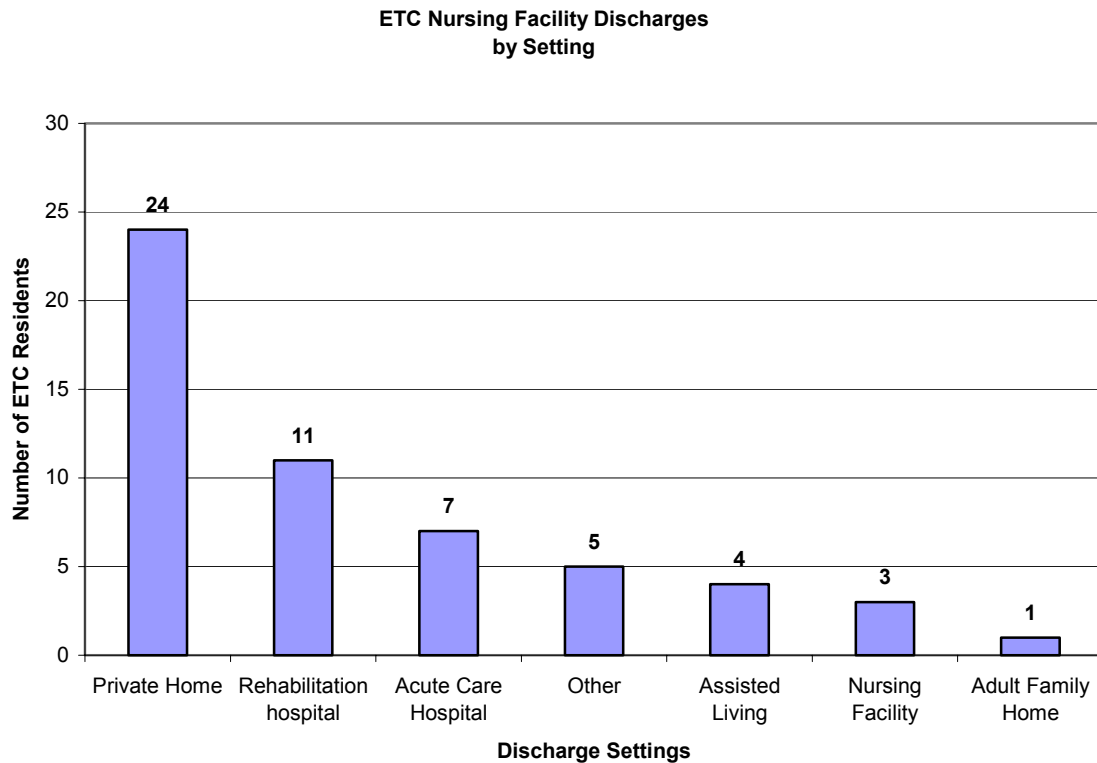
Table 5

Nursing Facility	Number of ETC Residents	Average LOS
A (Bel Air)	7	84.3 days
B (Colonial Vista Care)	3	25 days
C (Highland Terrace Nursing Ctr.)	9	58 days
D (Northgate Rehab Ctr.)	7	90.3 days
E (St. Lukes's Extended Care Ctr.)	3	23 days
F (WA Center for Comprehensive Rehab)	18	87.9 days

### Discharge Location

Chart 4 depicts the discharge location for the 55 residents who were discharged from the NF during the study time period.

Chart 4



The “other” category consists of dispositions such as death, leaving the facility against medical advice (AMA), jail, etc.

### Functional Improvement Using MDS-PAC Data

It is difficult to define “substantial progress” in functioning that is obtained through the provision of intensive therapy. A clinical representative from Uniform Data System (the organization that does the credentialing for the FIM tool) stated that the average FIM gain was 20 points for patients in an inpatient rehab facility, or in a subacute rehab program. Since the FIM was not used, and the FIM crosswalks with the MDS-PAC, we explored whether a comparable score from the MDS-PAC tool could be used to measure improvement.



First of all, the MDS-PAC data takes into account the following activities of daily living:

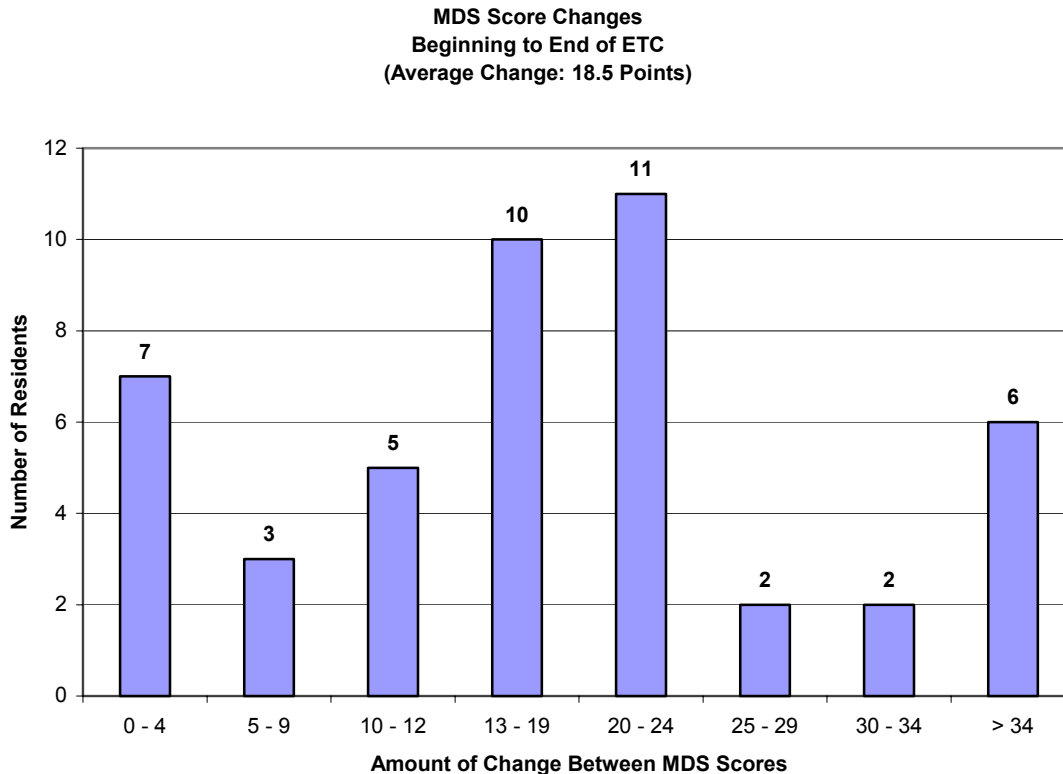
- bed mobility
- transfer to bed/chair
- locomotion
- walk in facility
- dressing upper body
- dressing lower body
- eating
- toilet use
- transfer on and off toilet
- grooming/personal hygiene
- bathing
- transfer tub/shower

By utilizing the possible range of ADL values for both the FIM, and the MDS-PAC tools, we can mathematically state that if the average gain for the FIM is 20 points, then a comparable gain for the MDS-PAC ADLs is 13. International research is being conducted to measure functional status using the MDS-PAC ADLS, but there are no studies yet available. For the purpose of this report, a difference of 13 points will be defined as substantial improvement. MDS data for both the beginning and ending of the ETC program was available for 48 residents. Almost two-thirds of the residents showed substantial improvement in ADL functioning using this definition, and demonstrated an average gain of 18.5 points. The data is presented in both a table (Table 6) and a graph format (Chart 5).

Table 6  
Substantial Improvement in ADL Functioning Using The MDS-PAC Tool

Yes	No
31/48= 65%	17/48= 35%

Chart 5



## **B. Cost of ETC Program**

The average NF cost per day (using the July 1, 2002 rate) is \$127.36. This amount is the average of those NFs participating in the pilot ETC program, and it does not include the daily therapy component. In addition to this amount, each pilot facility receives an add-on rate of approximately \$66.50 per day for each of its ETC residents. As of August 26, 2002 the additional money paid to facilities from January, 2000 through July, 2002 for ETC totaled \$134,101.70.

In addition to the add-on rate, each pilot NF also billed DSHS's Medical Assistance Administration (MAA) for the cost of the therapies. As of July 29, 2002, MAA had paid \$107,488.00 for the 42 ETC residents for whom billing had been submitted. This is an average of \$2,559.00 paid per resident. If we multiply this times 67 residents, we can estimate the total therapy cost at \$171,468.94.

In addition to the daily rate, the total cost for the ETC program for the time period of January 2000 through July 2002 is approximately \$305,570.64.

Had the ETC pilot program not been in place, these NFs would have received only the average daily rate of \$128.44 (which does include the therapy component).

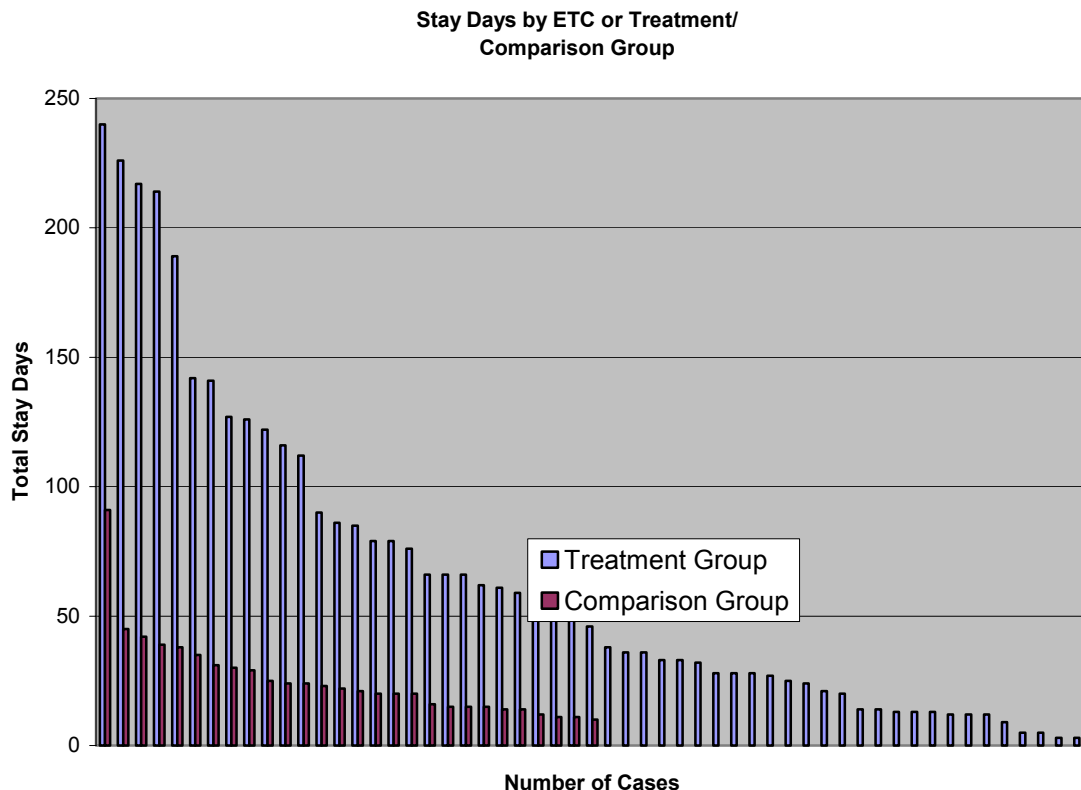
#### **IV. Comparison Group**

NF Minimum Data Set (MDS) data was utilized in order to create a group of comparable ETC residents. The characteristics of this comparison group are as follows:

- residing in NFs who were not participating in the ETC program
- met the ETC diagnostic criteria (residents had a diagnosis of CVA/stroke, or paraplegia, or quadriplegia, or TBI, or major multiple fractures)
- were under age 65 and not receiving Medicare benefits
- received at least two hours of skilled therapy/day, five days/week

For the time period of July 1, 2000 through June 30, 2001 there were 29 residents who met this criteria. Their NF length of stay ranged from 10 days to 222 days, with an average stay of 32.8 days. The resident with the 222-day length of stay was an outlier in that there were no other residents who approached that length of stay. When the data from the outlier resident is eliminated, the average length of stay for this population is reduced to 26 days (Chart 6).

Chart 6



Upon discharge these 29 comparison group residents went to the following locations:

Table 7

<b>Discharge Location (MDS Data)</b>	<b>Number of Comparison “ETC” Residents</b>
Home	20
Community Residential Setting	1
Another NF	1
Acute Care Facility	4
Rehabilitation Facility	3

There is no way to measure improvement in functional status for the comparison group as “point-in-time” data was used, and comparison between two MDSs was not possible.

## **V. Results**

Data on length of stay (LOS) as well as the discharge location was available for the comparison group and the ETC group.

The average LOS for the comparison group was less than half of what it was for the ETC or treatment group (26 days as opposed to 65 days).

Table 8 illustrates the discharge location data:

Table 8

<b>Comparison Group</b>	<b># of residents</b>	<b>%</b>	<b>ETC Group</b>	<b># of residents</b>	<b>%</b>
Home	20	69%	Home	24	44%
Rehab Hosp	3	10%	Rehab Hosp	11	20%
Acute Care Hosp	4	14%	Acute Care Hosp	7	13%
Other NF	1	3%	Other NF	3	5%
Community Residential	1	3%	Community Residential	5	9 %

The small numbers make it difficult to draw any statistical conclusions, but some general comments can be made between the two groups. The percentages for discharge location were comparable for discharges to an acute care hospital, and to another NF. The ETC group had more discharges to community residential settings and to rehabilitation hospitals. However, the ETC group had fewer discharges to home than the comparison group.

Data was not available to compare functional improvement between the two groups; however, one can assume that in order to discharge from a NF, there must have been improvement in resident functioning for the comparison group.

The NF residents in the comparison group had a shorter LOS and discharged a higher percentage of its residents to home than the residents in the ETC group. To address the goal of this legislative report, the data does not support that the availability of exceptional care payments for therapy care resulted in more expedient placement into less expensive settings, or other long-term cost savings.

## **VI. Discussion**

The difference in the LOS data was somewhat surprising, as the two groups appeared to be very comparable. In order to gain a better perspective on the data this writer contacted the director of rehabilitation in a NF with a large, active rehab unit. This NF collects LOS data for those residents in a Medicare part A stay. The range for those residents is 35 to 48 days with an average of 38 days; the director indicated that a stay of 48 days was unusually high, and not common. When asked about a LOS of 26 days for non-Medicare residents, the director remarked that it was “low, but definitely believable”. Even if a week or two were added for Medicaid only residents (38+14 days), that would increase the LOS to 52, still significantly lower than the 65 days that was seen in the ETC group.

This writer also interviewed five CNCs who performed the ETC monitoring reviews. They were asked the following questions:

- Would NFs provide the appropriate amount of skilled therapies without the ETC program? Two indicated that residents would get some therapy, but not as frequently nor as long without the ETC program. Two others felt that NFs would provide appropriate therapy anyway. One other felt that it depended on the NF; some were more accommodating than others.
- Should the ETC program be continued? Three said no; one of these indicated that intensive rehab should be provided to all residents that might achieve substantial benefit. Two felt that the program should be kept, but only in NFs that attract a younger population.

The question as to the availability and frequency of skilled rehabilitation services to Medicaid clients in NFs brings varied responses. From the data, it appears that Medicaid residents in NFs which are located near hospitals and receive many admissions requiring rehab therapy, receive more therapy than residents of non rehab focused NFs. Feedback was received from a therapist who stated that her NF administrator told her to provide the minimum amount of skilled therapy, unless the resident qualified for the ETC program. Also, upon interviewing DSHS’s NF case mix accuracy review coordinator, she stated that NFs (outside of the ETC pilot) are providing intensive skilled therapies to Medicaid residents.

There are at least two incentives for NFs to provide skilled therapy:

- The nursing home reform regulations (OBRA) passed in 1987, require NFs to help residents attain or maintain their highest practicable level of functioning. This means improvement when possible, or maintenance (prevention of avoidable decline).
- The NF case mix payment system may prompt NFs to provide more skilled rehabilitation as it may increase the average facility score for the direct care portion of their payment.

## **VII. Recommendation**

The data from the ETC pilot does not provide evidence that the availability of exceptional therapy care payments improved resident discharge placement or LOS. The data does not provide evidence that the ETC pilot program is cost effective. Therefore, DSHS does not recommend that this program be continued after the legislation expires on June 30, 2003.